

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/12/2015
NAME OF PROVIDER OR SUPPLIER WHITEHALL NORTH, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 300 WAUKEGAN ROAD DEERFIELD, IL 60015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)5) 300.3240a)</p> <p>Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin</p>	S9999	<p>Attachment A Statement of Licensure Violations</p>		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

08/31/15

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S9999	<p>Continued From page 1</p> <p>breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to do a complete skin assessment for one resident on admission. The facility failed to identify a pressure ulcer before it became unstageable. These failures resulted in R7 developing a painful, infected unstageable pressure ulcer requiring antibiotics and a wound vac (negative pressure wound therapy) for treatment and needing an extended stay (July 16, 2015 to August 13, 2015) at the facility. This applies to 1 of 2 residents (R7) reviewed for pressure ulcers in the sample of 24. The findings include: R7's Minimum Data Set (MDS) dated June 6, 2015 shows an admission date of May 30, 2015. R7 is cognitively intact, requires extensive assistance of two plus persons for toileting and is occasionally incontinent of bowel and bladder. R7's is 62 inches tall and weighs 202 pounds. The MDS shows she is at risk for developing pressure ulcers. R7's hospital transfer records dated May 30, 2015 show that she had back</p>	S9999			

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S9999	Continued From page 2 surgery on May 27, 2015 with an incision to her lower midline back with steri-strips applied. On August 11, 2015 at 12:10 PM, R7 was laying in bed. R7 pulled her pants down and turned on her left side to prepare for a dressing change. When R7 was on her side, no dressing was visible. E4 (Physical Therapist) spread R7's buttocks apart, removed a dressing from the sacral area and a 0.3 cm (centimeters) by 0.3 cm pressure ulcer was present. On August 12, 2015 at 9:45 AM, R7 said that she first noticed that she had something wrong with her bottom when they transferred her from the hospital to the facility. R7 said that when the ambulance transfer company first came to get her, they brought something that she had to sit upright on and she could not do this due to pain in her buttocks. They had to return with a stretcher so she could lie down. She also stated, "When I got here I was complaining about not being able to sit. They were giving me pain meds. When I was complaining of pain, they probably thought it was from my back surgery." R7 said that one day she was complaining of the pain again. They checked her buttocks and found the pressure ulcer. R7's Comprehensive Nursing Admission Assessment dated May 30, 2015 shows an admitting diagnoses of spinal stenosis and hemilaminectomy L4-L5. Under the heading skin, there was no description of any wound (including her surgical wound). R7's Nursing Notes dated June 3, 2015 shows, "Pt. (patient) noted with redness, excoriation along butt crack. Wound nurse notified." The June 7, 2015 Nursing Notes show, "patient has a very sensitive red buttocks." The June 8, 2015 Nursing Notes from E3 (Wound Nurse) shows, "Assessment to buttocks area shows some moisture related denuded skin at bilateral	S9999		

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S9999	Continued From page 3 buttocks/rectal area. Also noted at pre sacral area (which is difficult to see unless buttock cheeks are spread apart) was an unstageable ulcer with some redness and warmth to peri wound area." The June 12, 2015 Nursing Notes show, "P.T. (Physical Therapist) reports more depth and foul odor while doing dressing change to sacral wound. Pt. (patient) also reports more pain to the area. MD made aware and ordered Augmentin (antibiotic) for 7 days. The June 19, 2015 Nursing notes show, "Norco given for c/o (complaints of) buttocks pain." On August 12, 2015 at 11:20 AM, E3 (Wound Nurse) said that on June 8, 2015 she went in to see the excoriation to R7's buttocks that had been reported to her by the nurse. When she went in to look at the excoriation, "something made me open the crack up more and that is when I could see the unstageable ulcer." E3 also stated, "It was not visible to the naked eye unless you spread her butt cheeks way open." E3 said that when skin checks are performed, she uses a mirror and will look at every area of the body. She would have looked in the crease of her buttocks if she was doing a skin check. E3 said that R7's wound probably started as a deep tissue injury due to her history of sitting in a chair for over 30 days. E3 said a deep tissue injury is purple or maroon in color, non-blanchable and located over a bony prominence. E3 said that R7 would have had signs of a deep tissue injury at least 3-4 days prior to developing an unstageable pressure ulcer. E3 also said that if a resident is found with a deep tissue injury, treatment would be started right away. Treatment would include: protecting it with a foam dressing, starting ultrasound therapy, getting an air mattress, and dietary would be notified for a consult. E3 stated, "It really does help." R7 ' s Electronic Physician ' s Order record shows	S9999			

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S9999	<p>Continued From page 4</p> <p>an order start date for Augmentin for the sacral wound on June 12, 2015 for seven days. R7's Electronic Physician's Order record shows an order start date for a Wound Vac for a pre sacral ulcer on June 29, 2015.</p> <p>R7's Wound Care Addendum form dated June 8, 2015 shows an unstageable pressure ulcer on the pre sacral area/cleft measuring 4.5 cm by 1.8 cm. The wound was 100% (percent) black eschar (dead tissue) with 3 cm of red/warm surrounding tissue. R7's Wound Care Addendum notes dated June 29, 2015 shows a stage III pressure ulcer measuring 4.5 cm by 2 cm by 1.5 cm with 10% slough and 90% granulation tissue.</p> <p>R7's Braden Scale (Pressure ulcer risk scale) dated June 8, 2015 shows that she is at mild risk for the development of a pressure ulcer.</p> <p>R7's Medication Administration Record shows that she received Tylenol 325mg (milligrams), two tablets on May 31, 2015 at 4:00 PM, June 2, 2015 at 8:00 PM, June 3, 2015 at 8:17 PM, and June 11, 2015 at 9:51 PM for a pain level of 6.</p> <p>Location is not noted. The Medication Administration Record shows that she received Norco 5-325mg 1-2 tablets from June 12, 2015-June 17, 2015 for a pain level between 4 and 7. Location is not noted. On June 19, 2015, the Medication Administration record shows that R7 was given Norco 5-325mg, 2 tablets for buttock pain at a level of 10.</p> <p>R7's Plan of Care dated June 1, 2015 states that she was admitted to the facility for rehab. R7's Plan of Care for pressure ulcers and skin integrity shows an intervention with an effective date of June 3, 2015 that, "Skin will be checked during routine care on daily basis and during bath or shower. Concerns to be conveyed to Nurse."</p> <p>R7's Care Plan for pressure ulcers also shows an intervention with an effective date of June 8, 2015 that, "Skin assessment form to be done upon</p>	S9999			

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S9999	Continued From page 5 admission and quarterly." R7's undated Physical Therapy Discharge summary shows that on July 10, 2015 R7 stated, "My doctor wants me to stay until my wound is all closed up. It just takes so long." The summary also states that R7 was discharged from mobility Physical therapy on July 16, 2015. On August 12, 2015 at 12:10 PM, Z1 (Advanced Practice Nurse) said that R7's focus was on her back incision and not her buttocks. Z1 was unsure on how long R7 had had the pressure ulcer. Z1 said that the doctor started her on antibiotics for a possible infection due to the wound having an odor. The odor cleared up after receiving the antibiotics. Z1 also said R7 had to stay at the facility until her pressure ulcer healed. Z1 stated, "Just because no one looked, doesn't mean it wasn't there. They didn't look because that was not the issue." On August 12, 2015 at 12:00 PM, E2 (Director of Nursing) stated, "On my low risk for pressure ulcer residents, I don't expect them (nurses) to look in every nook and cranny. They usually just eyeball it." At 2:00 PM, E2 said R7 was not identified as a person who's "nooks and crannies" needed to be assessed. E2 stated, "When they (residents) come in, we don't look in the crack of a high functioning resident." The facility's undated Admission of a Resident policy shows, "Observe the condition of skin and scalp. Note any abnormalities of hair or skin (i.e., burns rash, pressure sores, dryness, surgical scars, dyspnea, diaphoresis, etc.)" The facility's undated skin care protocol shows, "Resident will be assessed upon admission and at least quarterly. For low and mild risk, residents will be assessed quarterly or as needed. On bath/shower days, resident will be observed for signs of redness." (B)	S9999		

